STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	08/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of 2 State hospital complaints. Complaint: #IN00143783: Substantiated; no deficiencies related to allegations are cited. #IN00152753: Unsubstantiated; allegation did not occur Survey Date: 8/4/14 Facility # 005051 Surveyors: Linda Dubak, R.N. Public Health Nurse Surveyor Nancy Otten, R.N. Public Health Nurse Surveyor Indiana University Health is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.5-10, Utilization review and discharge planning, Indiana Hospital Licensure Rules. QA: claughlin 09/08/14	S 000		